NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF QUALITY AND PATIENT SAFETY

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

HUDSON HEALTH PLAN, INC.

Reporting Year 2014

Published August 2016

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Acronyms Used in This Report

ALOS: *Average Length of Stay*
AO: *Area Office*

CHP: *Child Health Plus*
COM (C): *Commercial*

DBA: *Doing Business As*
DSS: *Data Submission System*

EQR: *External Quality Review*
EQRO: *External Quality Review Organization*

F/A: *Failed Audit*
FAR: *Final Audit Report*
FFS: *Fee For Service*
FHP: *Family Health Plus*
FTE: *Full Time Equivalent*

HCS: *Health Commerce System*
HEDIS: *Health Effectiveness Data and Information Set*
HIE: *Health Information Exchange*
HIT: *Health Information Technology*
HMO: *Health Maintenance Organization*
HPN: *Health Provider Network*

MCO: *Managed Care Organization*
MED (M): *Medicaid*
MMC: *Medicaid Managed Care*
MMCOR: *Medicaid Managed Care Operating Report*

N: *Denominator*
N/A: *Not Available*
NCQA: *National Committee for Quality Assurance*
NP: *Not Provided*
NR: *Not Reported*
NV: *Not Valid*
NYC: *New York City*
NYCRR: *New York Code Rules and Regulations*
NYSDOH: *New York State Department of Health*

OB/GYN: *Obstetrician/Gynecologist*
OPMC: *Office of Professional Medical Conduct*
OP: *Optimal Practitioner Contact*
OQPS: *Office of Quality and Patient Safety*

PCP: *Primary Care Practitioner/Provider*
PIP: *Performance Improvement Project*
PNDS: *Provider Network Data System*
POC: *Plan of Corrective Action*
PMPY: *Per Member Per Year*
PTMY: *Per Thousand Member Years*
PHSP: *Prepaid Health Services Plans*
PQI: *Prevention Quality Indicator*

Q1: *First Quarter (Jan. – March)*
Q2: *Second Quarter (Apr. – June)*
Q3: *Third Quarter (July – Sept.)*
Q4: *Fourth Quarter (Oct. – Dec.)*
QARR: *Quality Assurance Reporting Requirements*

R: *Rotated*
ROS: *Rest of State*
RY: *Reporting Year*

SN: *Safety Net*
SOD: *Statement of Deficiency*
SS: *Small Sample (Less than 30)*
SSI: *Supplemental Security Income*
SWA: *Statewide Average*

TANF: *Temporary Aid to Needy Families*
TR: *Technical Report*

UR: *Utilization Review*

I. About This Report

New York State (NYS) is dedicated to providing and maintaining the highest quality of care for enrollees in managed health care plans. The New York State Department of Health's (NYSDOH) Office of Quality and Patient Safety (OQPS) employs an ongoing strategy to improve the quality of care provided to plan enrollees, to ensure the accountability of these plans, and to maintain the continuity of care to the public.

The technical reports are individualized reports on the Managed Care Organizations (MCOs) certified to provide Medicaid coverage in NYS. In accordance with federal requirements, these reports summarize the results of the 2014 External Quality Review (EQR) to evaluate access to, timeliness of, and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per Federal Regulation 42 CFR 438.358) reported include validation of performance improvement projects (PIPs), validation of MCO-reported and NYSDOH-calculated performance measures, and review for MCO compliance with NYSDOH structure and operation standards. Optional EQR-related activities (as per Federal Regulation 42 CFR 438.358) reported include administration of a consumer survey of quality of care (CAHPS®) by an NCQA-certified vendor and technical assistance by the NYS EQRO to MCOs regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the following: health plan corporate structure, enrollment data, provider network information, encounter data summaries, and PQI/compliance/ satisfaction/quality points and incentive.

These reports are organized into the following domains: Corporate Profile, Enrollment and Provider Network, Utilization, Quality Indicators, and Deficiencies and Appeals. Although the reports focus primarily on Medicaid data, selected sections of these reports also include data from the MCOs' Child Health Plus (CHP), Family Health Plus (FHP), and Commercial product lines. For some measures, including QARR 2015 (MY 2014), aggregate rates are used, which represent the population of various product lines. These measures are noted as such. Additionally, when available and appropriate, the MCOs' data are compared with statewide benchmarks. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS®/QARR or CAHPS®, comparative statements are based on differences determined by standard deviations: a difference of one standard deviation is used to determine rates that are higher or lower than the statewide average.

Section VII provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness, and quality of services. For areas in which the MCO has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report. The MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

In an effort to provide the most consistent presentation of this varied information, the technical report is prepared based on data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for Reporting Year 2014.

II. MCO Corporate Profile

Hudson Health Plan, Inc. (Hudson) is a regional, not-for-profit prepaid health services plan (PHSP) that services Medicaid (MCD) and Child Health Plus (CHP) populations. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP product line.

- Plan ID: 2040287
- DOH Area Office: MARO
- Corporate Status: PHSP
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: June 22, 1987
- Product Lines: Medicaid and Child Health Plus
- Contact Information: 303 South Broadway, Suite 321
Tarrytown, NY 10591
(914) 631-1611
- NCQA Accreditation Status as of 08/31/14: Did not apply
- Medicaid Dental Benefit Status: Provided

Participating Counties and Products

Dutchess:	MCD	CHP	**Orange:**	MCD	CHP	**Rockland:**	MCD	CHP
Sullivan:	MCD	CHP	**Ulster:**	MCD	CHP	**Westchester:**	MCD	CHP

III. Enrollment and Provider Network

ENROLLMENT

Table 1 displays enrollment for the MCO's Medicaid product line for 2012, 2013, and 2014, as well as the percent change from the previous year. Enrollment has increased from 2013 to 2014 by a rate of 45.0%. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 1** trends enrollment for all product lines.

Table 1: Enrollment: Medicaid – 2012-2014

	2012	2013	2014
Number of Members	91,270	98,624	143,014
% Change From Previous Year		8.1%	45.0%

Data Source: MEDS II

Table 2: Enrollment: Other Product Lines – 2012-2014

	2012	2013	2014
FHP[1]	11,370	11,596	-
CHP	16,987	14,897	13,382

[1] In RY 2014, the MCO discontinued its Family Health Plus product line.

Figure 1: Enrollment Trends – All Product Lines

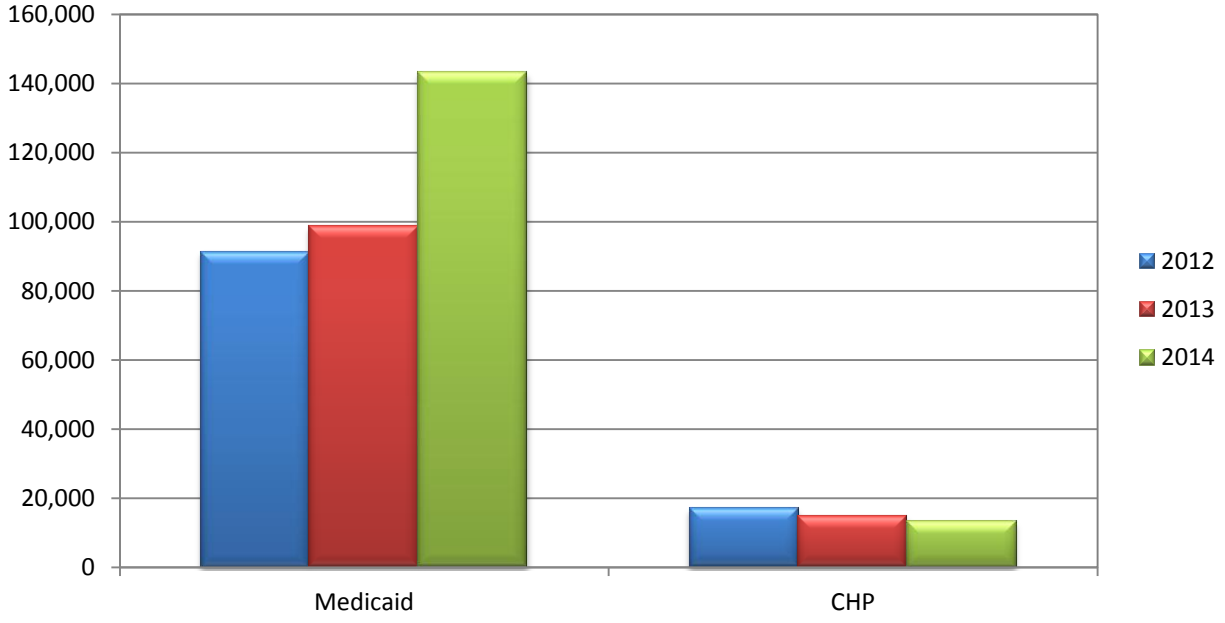
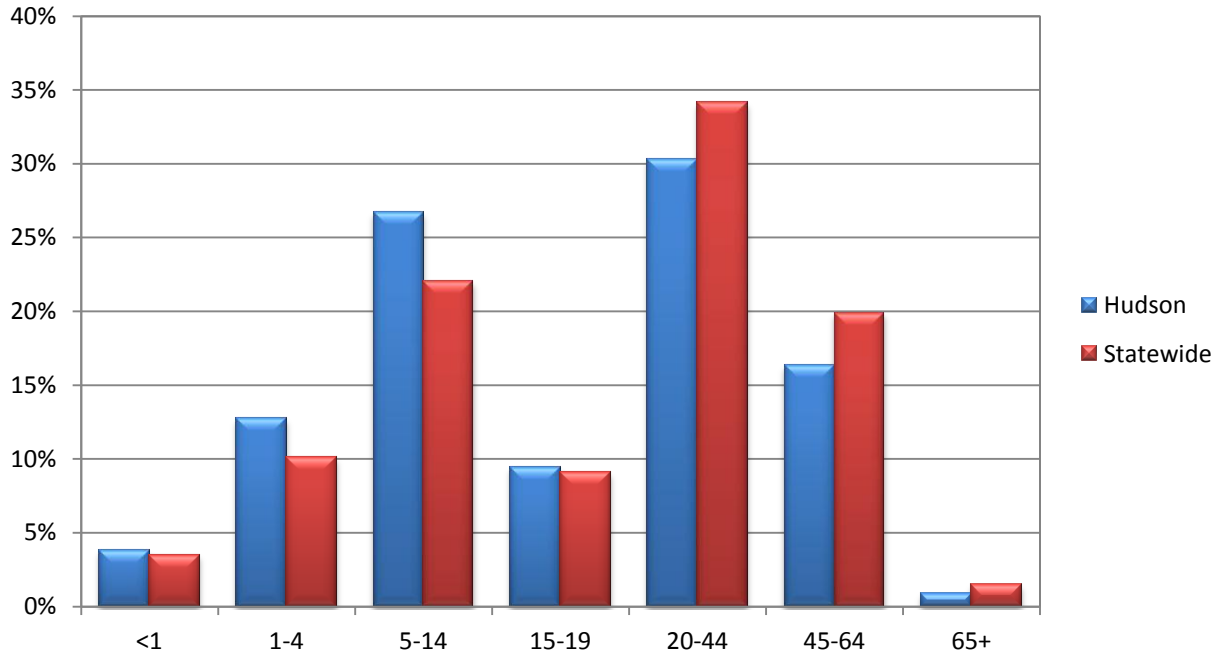


Table 3 and **Figure 2** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2014, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average.

Table 3: Medicaid Membership Age and Gender Distribution – December 2014

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	2,735	2,674	5,409	3.8%	3.5%
1-4	9,211	8,930	18,141	12.7% ▲	10.1%
5-14	19,546	18,618	38,164	26.7% ▲	22.0%
15-19	6,643	6,762	13,405	9.4%	9.1%
20-44	15,334	28,005	43,339	30.3% ▼	34.1%
45-64	9,975	13,347	23,322	16.3% ▼	19.9%
65 and Over	414	820	1,234	0.9%	1.5%
Total	**63,858**	**79,156**	**143,014**		
Under 20	38,135	36,984	75,119	52.5% ▲	44.6%
Females 15-64		48,114		33.6% ▼	36.1%

Figure 2: Medicaid Enrollees by Age – December 2014



PROVIDER NETWORK

Table 4 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2014 in comparison to the statewide percentages. For this table, MCO percentages above statewide rates are indicated by ▲, while percentages below the statewide rates are indicated by ▼.

Table 4: Medicaid Providers by Specialty – 2014 (4th Quarter)

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	1,098	9.6% ▼	19.8%
Pediatrics	355	3.1% ▼	4.5%
Family Practice	228	2.0% ▼	3.9%
Internal Medicine	369	3.2% ▼	8.9%
Other PCPs	146	1.3% ▼	2.5%
OB/GYN Specialty[1]	507	4.4%	4.1%
Behavioral Health	2,036	17.9%	19.6%
Other Specialties	6,088	53.4% ▲	43.6%
Non-PCP Nurse Practitioners	219	1.9% ▼	5.7%
Dentistry	613	5.4%	6.2%
Unknowns	845	7.4% ▲	0.9%
Total	**11,406**		

Data Source: HCS

[1] Includes OB/GYN specialists, certified nurse midwives, and OB/GYN nurse practitioners.

Table 5 displays the ratio of enrollees to providers for the MCO's Medicaid product line. Statewide data are also included. For this table, rates above the 90th percentile are indicated by ▲, while rates below the 10th percentile are indicated by ▼. Note that a higher percentile indicates fewer providers per enrollee.

Table 5: Ratio of Enrollees to Medicaid Providers – 2014 (4th Quarter)

	Hudson	Statewide
	Ratio of Enrollees to Providers	Median Ratio of Enrollees to Providers[1]
Primary Care Providers	130:1 ▲	47:1
Pediatricians (Under Age 20)	212:1 ▲	95:1
OB/GYN (Females Age 15-64)	95:1 ▲	42:1
Behavioral Health	70:1	56:1

Data Source: Derived Medicaid ratios calculated from MEDS II enrollment data and HCS provider data.

[1] The statewide median was used for this table, as opposed to an average, to control for substantial variability due to outliers.

Table 6 displays HEDIS®/QARR *Board Certification* rates for 2012 through 2014 of providers in the MCO's network in comparison to the statewide averages. The table also indicates whether the MCO's rate was above (indicated by ▲) or below (indicated by ▼) the statewide average.

Table 6: HEDIS®/QARR Board Certification Rates – 2012-2014

Provider Type	2012[1]		2013		2014	
	Hudson	Statewide Average	Hudson	Statewide Average	Hudson	Statewide Average
Medicaid/CHP						
Family Medicine	84%	78%	81%	78%	79%	77%
Internal Medicine	76%	80%	77%	78%	77%	77%
Pediatricians	89% ▲	81%	78%	80%	86%	80%
OB/GYN	83%	74%	74%	78%	78%	75%
Geriatricians	SS	70%	SS	69%	SS	64%
Other Physician Specialists	86% ▲	78%	82% ▲	78%	83% ▲	76%

SS: Sample size too small to report (less than 30 providers) but included in the statewide average.
[1] For RY 2012, rates reflect the Medicaid product line only.

PRIMARY CARE AND OB/GYN ACCESS AND AVAILABILITY SURVEY – 2014

On behalf of the NYSDOH's Division of Health Plan Contracting and Oversight, the NYS EQRO conducts the Medicaid Managed Care Access and Availability Survey to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements as per the NYS Medicaid/Family Health Plus Managed Care Contract. The survey evaluates the availability of routine and non-urgent "sick" office hour appointments with primary care physicians, including OB/GYNs, as well as the availability of after hours access.

The timeliness standard for routine office hour appointments with PCPs and OB/GYNs is within 28 days of the enrollee's request, while non-urgent "sick" office hour appointments with PCPs and OB/GYNs must be scheduled within 72 hours (excluding weekends and holidays) as clinically indicated. Prenatal appointments with OB/GYN providers within the 2nd trimester must be given within 14 days, while 3rd trimester appointments must be given within 7 days. After hours access is considered compliant if a "live voice" representing the named provider is reached or if the named provider's beeper number is reached.

A random sample of 240 provider sites was selected from each region in which the MCO operated and provided primary care as a Medicaid and/or Family Health Plus benefit. Of these 240 provider sites, 120 were surveyed for routine appointments, 80 were surveyed for non-urgent "sick" appointments, and 40 were surveyed for after hours access. For MCOs with less than the 240 available provider sites, all providers were selected.

For call type categories in which compliance is below the 75% threshold, MCOs will receive a Statement of Deficiency (SOD) issued by the NYSDOH and will be required to develop a Plan of Correction (POC). These POCs must be approved by the NYSDOH before implementation. Following an allowable time period for MCOs to execute their POCs, a resurvey of the failed providers will be conducted.

Table 7 displays the seven regions in New York State, as well as the MCOs operating in each region that offered primary care and obstetrics/gynecological benefits to its Medicaid members at the time of the survey.

Table 7: Provider Network: Access and Availability Survey – Region Details – 2014

Region Name	Counties	MCOs Operating in Region
Region 1: Buffalo	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming	Excellus Health Plan, Inc.; Fidelis Care New York; HealthNow New York, Inc.; Independent Health Association, Inc.; MVP Health Plan, Inc.; and Univera Community Health, Inc.
Region 2: Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates	Excellus Health Plan, Inc.; Fidelis Care New York; and MVP Health Plan, Inc.
Region 3: Syracuse	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, and Tompkins	Capital District Physicians' Health Plan, Inc.; Excellus Health Plan, Inc.; Fidelis Care New York; SCHC Total Care, Inc.; and UnitedHealthcare Community Plan
Region 4: Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington	Capital District Physicians' Health Plan, Inc.; Excellus Health Plan, Inc.; Fidelis Care New York; UnitedHealthcare Community Plan; and WellCare of New York, Inc.
Region 5: New Rochelle	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester	Affinity Health Plan, Inc.; AMERIGROUP New York, LLC; Fidelis Care New York; Health Insurance Plan of Greater New York; Hudson Health Plan, Inc.; MVP Health Plan, Inc.; UnitedHealthcare Community Plan; and WellCare of New York, Inc.
Region 6: New York City	Bronx, Kings, New York, Queens, and Richmond	Affinity Health Plan, Inc.; AMERIGROUP New York, LLC; Amida Care, Inc.; Fidelis Care New York; Healthfirst PHSP, Inc.; Health Insurance Plan of Greater New York; MetroPlus Health Plan, Inc.; MetroPlus Health Plan, Inc. Special Needs Plan; UnitedHealthcare Community Plan; VNS Choice SelectHealth; and WellCare of New York, Inc.
Region 7: Long Island	Nassau and Suffolk	Affinity Health Plan, Inc.; AMERIGROUP New York, LLC; Fidelis Care New York; Healthfirst PHSP, Inc.; Health Insurance Plan of Greater New York; and UnitedHealthcare Community Plan

Table 8 displays the MCO's Primary Care and OB/GYN Access and Availability results for 2014. The MCO met the 75% threshold for all call types in Region 5.

Table 8: Provider Network: Access and Availability Survey Results – 2014

Region	Call Type	Hudson	Region Average
Region 5	Routine	86.7%	78.3%
	Non-Urgent "Sick"	78.8%	74.0%
	After Hours Access	87.5%	75.3%

IV. Utilization

This section of the report explores utilization of the MCO's services by examining encounter data, as well as QARR Use of Services rates.

ENCOUNTER DATA

Table 9 displays selected Medicaid encounter data for 2012 through 2014. The MCO's rates for these periods are also compared to the statewide averages. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼.

Table 9: Medicaid Encounter Data – 2012-2014

	Encounters (PMPY)					
	2012		2013		2014	
	Hudson	Statewide Average	Hudson	Statewide Average	Hudson	Statewide Average
PCPs and OB/GYNs	4.32	4.24	4.26	4.45	4.10	4.36
Specialty	2.71 ▲	2.04	2.71 ▲	1.90	2.71 ▲	1.94
Emergency Room	0.72	0.60	0.70	0.60	0.95 ▼	2.11
Inpatient Admissions	0.16	0.15	0.15	0.14	0.14	0.15
Dental – Medicaid	1.14	1.03	1.20	1.00	1.19	1.03
Dental – FHP	1.17	1.12	1.13	1.04	1.02	1.02

Data Source: MEDS II
PMPY: Per Member Per Year

QARR USE OF SERVICES MEASURES

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentiles. **Table 10** lists the Use of Services rates for the selected product lines for 2012 through 2014. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼).

Table 10: QARR Use of Services – 2012-2014

Measure	Medicaid/CHP			
	2012[1]	2013	2014	2014 Statewide Average
	Outpatient Utilization (PTMY)			
Visits	5,732	5,485	4,541	5,366
ER Visits	720	642	588	555
	Inpatient ALOS			
Medicine	3.9	4.2	4.9 ▲	4.3
Surgery	6.5	7.4	6.3	6.4
Maternity	3.0	2.9	2.9	2.8
Total	4.1	4.3	4.5	4.2
	Inpatient Utilization (PTMY)			
Medicine Cases	43	35	33	40
Surgery Cases	24 ▲	17	14	13
Maternity Cases	69 ▲	54 ▲	43	36
Total Cases	111	86	77	79

PTMY: Per Thousand Member Years

ALOS: Average Length of Stay. These rates are measured in days.

[1] For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

V. Quality Indicators

To measure the quality of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports, including HEDIS®/QARR 2015 audit findings, as well as results of quality improvement studies, enrollee surveys, and MCO Performance Improvement Projects (PIPs).

VALIDATION OF PERFORMANCE MEASURES

Performance measures are reported and validated using several methodologies. MCOs submitted member- and provider-level data for several measures to the NYSDOH. The NYS EQRO audited all member- and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, MCOs report a subset of HEDIS® measures to the NYSDOH annually, along with several NYS-specific measures. MCO-reported performance measures were validated as per HEDIS® 2015 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA).

For measurement year (MY) 2014, the methodology for reporting performance measure rates was modified. Previously, Medicaid and Child Health Plus were reported separately; however, for QARR 2015 (MY 2014), rates for these populations were combined, following HEDIS® methodology (summing numerators and denominators from each population). Although the data presented in this report for MY 2012 are Medicaid only (unless otherwise specified), trend analysis has been applied over the time period 2012 through 2014, as the effect of combining the CHP and Medicaid populations was determined to be negligible through an analysis of historical QARR data.

The results of each MCO's HEDIS® 2015 Compliance Audit™ are summarized in its Final Audit Report (FAR).

SUMMARY OF HEDIS® 2015 INFORMATION SYSTEM AUDIT™

As part of the HEDIS® 2015 Compliance Audit™, auditors assessed the MCO's compliance with NCQA standards in the six designated information system categories, as follows:

1. Sound Coding Methods for Medical Data
2. Data Capture, Transfer, and Entry – Medical Data
3. Data Capture, Transfer, and Entry – Membership Data
4. Data Capture, Transfer, and Entry – Practitioner Data
5. Data Integration Required to Meet the Demands of Accurate HEDIS® Reporting
6. Control Procedures that Support HEDIS® Reporting and Integrity

In addition, two HEDIS®-related documentation categories were assessed:

1. Documentation
2. Outsourced or Delegated HEDIS® Reporting Functions

The NYS EQRO provided technical assistance to MCOs throughout the performance measure reporting process in the following forms: 1) introductory and technical workshops prior to the audit, 2) readiness reviews for new MCOs, 3) serving as a liaison between the MCOs and NCQA to clarify questions regarding measure specifications, 4) preparation of and technical support for the Data Submission System (DSS) used to submit data to the NYSDOH, and 5) clarifications to MCO questions regarding the submission of member- and provider-level data, as well as general questions regarding the audit process.

The HEDIS® 2015 Final Audit Report (FAR) prepared for Hudson indicated that the MCO had no significant problems in any area related to reporting. The MCO demonstrated compliance with all areas of the Information Systems and all areas of measure determination required for successful HEDIS®/QARR reporting.

The MCO used NCQA-certified software to produce HEDIS® measures. Supplemental databases used to capture additional data were validated and determined to be HEDIS®-compliant by the auditors.

Hudson passed Medical Record Review for the three measures validated, as well as for Exclusions. The MCO was able to report all measures for the Medicaid product line.

Table 11 displays QARR performance rates for Measurement Years 2012, 2013, and 2014, as well as the statewide averages (SWAs). The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table Notes for Table 11	
R:	Rotated measure.
NR:	Not reported.
NP:	Dental benefit not provided.
FY:	First-Year Measure, MCO-specific rates not reported.
SS:	Sample size too small to report (less than 30 members) but included in the statewide average.

Table 11: QARR MCO Performance Rates – 2012-2014

Measure	Medicaid/CHP			
	2012[1]	2013	2014	2014 SWA
Follow-up Care for Children on ADHD Meds – Continue	72	68	71	67
Follow-up Care for Children on ADHD Meds – Initial	62	56	58	58
Adolescents – Alcohol and Other Drug Use	R	66	R	R
Adolescents – Depression	R	59	R	R
Adolescents – Sexual Activity	R	62	R	R
Adolescents – Tobacco Use	R	69	R	R
Adolescent Immunization – Combo	70	77 ▲	R	R
Adolescent Immunization – HPV	FY	28	29	28
Adult BMI Assessment	86 ▲	91 ▲	R	R
Flu Shots for Adults (Ages 18-64)		42	R	R
Advising Smokers to Quit	R	78	R	R
Follow-up After Hospitalization for Mental Illness – 30 Days	87 ▲	83 ▲	83 ▲	78
Follow-up After Hospitalization for Mental Illness – 7 Days	76 ▲	67	67	63
Antidepressant Medication Management – Continue	35	32	33	35
Antidepressant Medication Management – Acute Phase	54	49	50	50
Drug Therapy for Rheumatoid Arthritis	65 ▼	69 ▼	69 ▼	81
Appropriate Meds for People with Asthma (Ages 19-64)	80	81	79	78
Appropriate Meds for People with Asthma (Ages 5-18)	88 ▲	89 ▲	89 ▲	85
Asthma Medication Ratio (Ages 19-64)	FY	56	57	53
Asthma Medication Ratio (Ages 5-18)	FY	73	70 ▲	61
Use of Imaging Studies for Low Back Pain	73 ▼	71 ▼	71 ▼	77
Persistence of Beta-Blocker Treatment After a Heart Attack	SS	SS	79	86
Avoidance of Antibiotics for Adults with Acute Bronchitis	18 ▼	23	24	28
Chlamydia Screening (Ages 16-24)	70	71	67 ▼	72
Colon Cancer Screening	R	55	R	R
Dental Visit (Ages 19-21)	45	44	43	43
Annual Dental Visits (Ages 2-18)	65 ▲	68 ▲	66 ▲	60
Diabetes BP Controlled (<140/90 mm Hg)	R	77 ▲	R	R
Diabetes HbA1c below 8%	R	62 ▲	R	R
Diabetes Eye Exam	R	62	R	R

[1] For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

Table 11: QARR MCO Performance Rates – 2012-2014 (continued)

Measure	Medicaid/CHP			
	2012[1]	2013	2014	2014 SWA
Diabetes Nephropathy Monitor	R	80	R	R
Diabetes HbA1c Test	R	90	R	R
HIV – Engaged in Care	90	91 ▲	86	81
HIV – Syphilis Screening	63	74	71	73
HIV – Viral Load Monitoring	64	78 ▲	68	71
Childhood Immunization – Combo 3	R	78 ▲	R	R
Lead Testing	R	86 ▼	R	R
Breast Cancer Screening	64 ▼	70	67 ▼	71
Smoking Cessation Medications	R	58	R	R
Medical Management for People with Asthma 50% (Ages 19-64)	53 ▼	60 ▼	61 ▼	66
Medical Management for People with Asthma 50% (Ages 5-18)	36 ▼	45 ▼	43 ▼	50
Smoking Cessation Strategies	R	48	R	R
Monitor Patients on Persistent Medications – Combined	90	91	89 ▼	92
Pharmacotherapy Management for COPD – Bronchodilator	88	88	90	88
Pharmacotherapy Management for COPD – Corticosteroid	67	77	74	75
Testing for Pharyngitis	80 ▼	86	90 ▲	88
Diabetes Monitoring for Schizophrenia	FY	81	73	78
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	FY	86	82	82
Antipsychotic Meds for Schizophrenia	FY	63	62	61
Spirometry Testing for COPD	54	40 ▼	45 ▼	53
Treatment for Upper Respiratory Infection	94 ▲	93	94 ▲	93
Well-Child Visits – First 15 Months	73 ▲	71 ▲	68	66
Well-Child Visits – 3 to 6 Year Olds	80 ▼	86 ▲	76 ▼	84
Well-Care Visits for Adolescents	55 ▼	64	58 ▼	65
Children BMI	R	88 ▲	R	R
Children Counseling for Nutrition	R	82 ▲	R	R
Children Counseling for Physical Activity	R	79 ▲	R	R

[1] For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

QARR ACCESS TO/AVAILABILITY OF CARE MEASURES

The QARR Access to/Availability of Care measures examine the percentages of children and adults who access certain services, including PCPs or preventive services, prenatal and postpartum care, and dental services for selected product lines. **Table 12** displays the Access to/Availability of Care measures for Measurement Years 2012 through 2014. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of MCOs for that measure (indicated by ▼).

Table 12: QARR Access to/Availability of Care Measures – 2012-2014

Measure	Medicaid/CHP			
	2012[1]	2013	2014	2014 SWA
Children and Adolescents' Access to PCPs (CAP)				
12 – 24 Months	98% ▲	98% ▲	98% ▲	97%
25 Months – 6 Years	95% ▲	96% ▲	93% ▼	94%
7 – 11 Years	96%	97% ▲	96%	97%
12 – 19 Years	93%	95% ▲	94%	94%
Adults' Access to Preventive/Ambulatory Services (AAP)				
20 – 44 Years	86% ▲	86% ▲	83% ▼	84%
45 – 64 Years	90%	91%	89% ▼	91%
65+ Years	91%	91%	90%	90%
Access to Other Services				
Timeliness of Prenatal Care	92% ▲	R	93% ▲	88%
Postpartum Care	75% ▲	R	74% ▲	69%
Annual Dental Visit[2]	64% ▲	66% ▲	64% ▲	58%

R: Rotated measure

[1] For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

[2] For the Annual Dental Visit measure, the Medicaid/FHP age group is 2-21 years, while the Child Health Plus age group is 2-18 years.

NYSDOH-CALCULATED QARR PRENATAL CARE MEASURES

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, as well as from NYSDOH's Vital Statistics Birth File. Since some health events such as low birth weight births and cesarean deliveries do not occur randomly across all MCOs, risk adjustment is used to remove or reduce the effects of confounding factors that may influence an MCO's rate. **Table 13** presents prenatal care rates calculated by the NYSDOH for QARR 2011 through 2013. In addition, the table indicates if the MCO's rate was significantly better than the average (indicated by ▲) or whether the MCO's rate was significantly worse than the average (indicated by ▼).

Table 13: QARR Prenatal Care Measures – 2011-2013

Measure	2011		2012		2013	
	Hudson	NYC/ROS Average	Hudson	NYC/ROS Average	Hudson	NYC/ROS Average
			ROS			
Risk-Adjusted Low Birth Weight[1]	7%	7%	7%	7%	7%	7%
Prenatal Care in the First Trimester	69%	71%	69%	71%	73%	72%
Risk-Adjusted Primary Cesarean Delivery[1]	20% ▼	15%	16%	15%	18%	15%
Vaginal Birth After Cesarean	7%	11%	7%	11%	8%	12%

[1] A low rate is desirable for this measure.
ROS: Rest of State

MEMBER SATISFACTION

In 2014, the CAHPS® survey for child Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. Surveys were administered to parents/caretakers of Medicaid enrollees aged 0-17 years. **Table 14** displays the question category, the MCO's rates, and the statewide averages for Measurement Year 2014. The table also indicates whether the MCO's rate was significantly better than the statewide average (SWA) (indicated by ▲) or whether the MCO's rate was significantly worse than the SWA (indicated by ▼).

Table 14: Child CAHPS® – 2012 and 2014

	Medicaid			
	2012		2014	
	Hudson	Statewide Average	Hudson	Statewide Average
Coordination of Care[1]	75	74	74	74
Getting Care Needed[1]	82	78	86	83
Satisfaction with Provider Communication[1]	94	93	93	93
Customer Service[1]	93 ▲	85	89 ▲	82
Collaborative Decision Making[1]	87	87	55	53
Getting Information	87	82	91	89
Rating of Healthcare	85	83	88	85
Rating of Personal Doctor[1]	87	88	88	88
Getting Care Quickly[1]	87	86	88	87
Rating of Counseling	58	63	64	64
Overall Rating of Health Plan	89 ▲	82	89 ▲	83
Rating of PCP	91	89	91	89
Rating of Specialist	80	78	85	81
Access to Specialized Services[1]	77	71	73	76

[1] These indicators are composite measures.

QUALITY PERFORMANCE MATRIX ANALYSIS – 2014 MEASUREMENT YEAR

Table 15 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Use of Services and Access to/Availability of Care measures reported annually in the New York State Managed Care Plan Performance Report. Twenty-eight measures were selected for the 2014 Measurement Year (MY) Quality Performance Matrix, which include combined measures for Medicaid and CHP product lines. The matrix diagrams the MCO's performance in relation to its previous year's quality rates and also compares its rates to those of other Medicaid Managed Care Organizations through a percentile ranking.

For the MY 2012 Quality Performance Matrix, the NYSDOH made modifications in order to focus on those measures in need of the most improvement statewide. For previous measurement years, the cell category (A-F) was determined by the year-over-year trend of the measure (vertical axis) and by any significant difference from the statewide average (horizontal axis). For the 2012 MY, the matrix was reformatted to maintain the year-over-year evaluation on the vertical axis, but to evaluate the MCO's performance based on a percentile ranking on the horizontal axis. The new percentile ranking was partitioned into three categories: 0-49th percentile, 50th-89th percentile, and 90th-100th percentile. The 2012 matrix included only those measures for which the 2011 Medicaid statewide average was less than a predetermined benchmark; however, for MY 2014, additional measures were included to provide MCOs with a broader overview of quality performance, and further assist MCOs in identifying and prioritizing quality improvement.

With the issuance of the 2008 MY Matrix, the NYSDOH modified its MCO requirements for follow-up action. In previous years, MCOs were required to develop root cause analyses and plans of action for all measures reported in the D and F categories of the matrix. Starting with the 2008 MY Matrix, MCOs were required to follow-up on no more than three measures from the D and F categories of the matrix. However, if an MCO had more than three measures reported in the F category, the MCO was required to submit root cause analyses and plans of action on all measures reported in the F category. For the MY 2014 Matrix, this requirement was modified, requiring the MCO to submit a maximum of three root cause analyses and plans of action, regardless of the number of measures reported in the F category. Beginning with MY 2008, if an MCO has fewer than three measures reported in the F category, the remaining measures must be selected from the D category for a total of three measures. If the MCO has no measures in the D and F categories, the MCO is not required to follow-up.

Table 15: Quality Performance Matrix – 2014 Measurement Year

Trend *	Percentile Ranking 0 to 49%	50 to 89%	90 to 100%
⬆	**C**	**B** Appropriate Testing for Pharyngitis	**A** Frequency of Ongoing Prenatal Care
No Change	**D** Avoid Antibiotics for Adults with Acute Bronchitis Breast Cancer Screening Chlamydia Screening (Ages 16-24) Drug Therapy for Rheumatoid Arthritis Medical Mgmt for People with Asthma 50% (Ages 19-64) Medical Mgmt for People with Asthma 50% (Ages 5-18) Pharmacotherapy Mgmt for COPD-Corticosteroid Spirometry Testing for COPD Use of Imaging Studies for Low Back Pain Well-Care Visits for Adolescents	**C** Antidepressant Medication Management-Acute Phase Antipsychotic Meds for Schizophrenia Asthma Medication Ratio (Ages 19-64) Cervical Cancer Screening Controlling High Blood Pressure FU After Hospitalization for Mental Illness-7 Days FU for Child on ADHD Meds-Initial Well-Child Visits-First 15 Months (5+ visits)	**B** Annual Dental Visits (Ages 2-18) Asthma Medication Ratio (Ages 5-18) Postpartum Care
⬇	**F** Diabetes Monitoring for Schizophrenia Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds Well-Child Visits-3 to 6 Year Olds	**D** HIV-Engaged in Care	**C**

NYSDOH QUALITY INCENTIVE

The percentage of the potential financial incentive that an MCO receives is based on quality of care, consumer satisfaction, and compliance. Points earned are derived from an algorithm that considers QARR 2015 (MY 2014) rates in comparison to statewide percentiles, the most recent Medicaid CAHPS® scores, and compliance information from MY 2012 and MY 2013. The total score, based out of 150 possible points, determines what percentage of the available premium increase the MCO qualifies for. For 2014, there were four levels of incentive awards that could be achieved by MCOs based on the results. **Table 16** displays the points the MCO earned from 2012 to 2014, as well as the percentage of the financial incentive that these points generated based on the previous measurement year's data. **Table 17** displays the measures that were used to calculate the 2014 incentive, as well as the points the MCO earned for each measure.

Table 16: Quality Incentive – Points Earned – 2012-2014

	2012		2013		2014	
	Hudson	Statewide Average	Hudson	Statewide Average	Hudson	Statewide Average
Total Points (150 Possible Points)	95	78.4	132.4	80.8	91	73.8
PQI Points (20 Possible Points)	13	9.9	10	6.9	15	6.9
Compliance Points (-20 Possible Points)	-6	-5.3	-4	-5.4	-2	-4
Satisfaction Points (30 Possible Points)	25	15.9	60	15.9	25	16.3
Quality Points[1] (100 Possible Points)	63	57.9	96	63.4	53	54.5
Percentage of Financial Incentive Earned	75%		100%		75%	

[1] Quality Points presented here are normalized.

Table 17: Quality Incentive – Measures and Points Earned – 2014

Measure	MCO Points
PQI	**15.0**
Adult Prevention Composite PQI *(10 points)*	7.5
Pediatric Composite PDI *(10 points)*	7.5
Compliance *(-4 points, except where noted)*	**-2.0**
MEDS	0.0
MMCOR	0.0
QARR	0.0
Provider Directory *(-2 points)*	-2.0
Member Services	0.0
Satisfaction *(10 points each)*	**25.0**
Rating of Health Plan (CAHPS®)	10.0
Getting Care Needed (CAHPS®)	5.0
Customer Service and Information (CAHPS®)	10.0
Quality *(3.84 points each, except where noted)*	**33.6**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1.92
Antidepressant Medication Management—Effective Acute Phase Treatment	1.92
Appropriate Testing for Pharyngitis	2.88
Asthma Medication Ratio (Ages 5-18) *(1.92 points)*	1.92
Asthma Medication Ratio (Ages 19-64) *(1.92 points)*	0.96
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	0.0
Breast Cancer Screening	0.0
Cervical Cancer Screening	1.92
Chlamydia Screening (Ages 16-24)	0.0
Comprehensive Care for People Living with HIV/AIDS—Engaged in Care	1.92
Controlling High Blood Pressure	1.92
Diabetes Monitoring for People with Diabetes and Schizophrenia	0.0
Diabetes Screen for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	0.0
Disease-Modifying Anti-Rheumatic Drugs for Rheumatoid Arthritis	0.0
Follow-Up After Hospitalization for Mental Illness Within 7 Days	1.92
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	1.92
Medication Management for People with Asthma 50% Days Covered (Ages 5-18) *(1.92 points)*	0.0
Medication Management for People with Asthma 50% Days Covered (Ages 19-64) *(1.92 points)*	0.0
Persistence of Beta-Blocker Treatment After a Heart Attack	0.0
Pharmacotherapy Management of COPD Exacerbation—Corticosteroid	0.0
Use of Imaging Studies for Low Back Pain	0.0
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0.0
Annual Dental Visit (Ages 2-18)	3.84
Frequency of Ongoing Prenatal Care	3.84
Postpartum Care	3.84
Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	2.88
Well-Child & Preventive Care Visits in 3rd, 4th, 5th, & 6th Year of Life	0.0
Well-Care Visits for Adolescents	0.0
Total Normalized Quality Points[1]	**53.0**
Total Points Earned	**91.0**

MMCOR: Medicaid Managed Care Operating Report

MEDS: Medicaid Encounter Data Set

[1] Quality Points were normalized before being added to the total points earned. The points each MCO earned for each quality measure were aggregated and converted to normalized quality points. Quality points were normalized in order to control for a difference in base points, as not every MCO could earn points for each measure due to small sample sizes (less than 30 members).

PERFORMANCE IMPROVEMENT PROJECT

Each MCO is required by the Medicaid Health Maintenance Organization contract to conduct at least one Performance Improvement Project (PIP) each year. A PIP is a methodology for facilitating MCO- and provider-based improvements in quality of care. PIPs place emphasis on evaluating the success of interventions to improve quality of care. Through these projects, MCOs and providers determine what processes need to be improved and how they should be improved.

The NYS EQRO provided technical assistance to MCOs throughout the PIP process in the following forms:
1) review of the MCO's Project Proposal prior to the start of the PIP; 2) quarterly teleconferences with the MCO for progress updates and problem-solving; 3) feedback on methodology, data collection tools, and implementation of interventions; and 4) feedback on drafts of the MCO's final report.

In addition, the NYS EQRO validated the MCO's PIP by reviewing the project topic, aim statement, performance indicators, study population, sampling methods (if sampling was used), data collection procedures, data analysis, and interpretation of project results, as well as assessing the MCO's improvement strategies, the likelihood that the reported improvement is "real" improvement, and whether the MCO is likely to be able to sustain its documented improvement. Validation teams met quarterly to review any issues that could potentially impact the credibility of PIP results, thus ensuring consistency among validation teams. The validation process concluded with a summary of the strengths and opportunities for improvement in the conduct of the PIP, including any validation findings that indicated the credibility of the PIP results was at risk.

Hudson's 2013-2014 PIP topic is *"There Must Be a Better Way – Tobacco Cessation Program"*. Throughout the conduct of the PIP, the MCO implemented the following interventions:

- Published articles in the Member and Provider Newsletters regarding tobacco cessation counseling.
- Distributed waiting room tear-off pads for providers to use to attract patient attention and encourage patients to discuss smoking cessation.
- Sent mailing card and made phone call to members who self-identified as smokers during new member orientation.
- Promoted "There must be a better way" campaign at all 2013 community events by handing out cards and tear-off sheets to individuals who smoke or have family members who smoke.

Table 18 presents a summary of Hudson's 2013-2014 PIP.

Table 18: Performance Improvement Project – 2013-2014

Indicators	Results
Smoking Cessation Counseling Rate	Performance level maintained
Counseling Rate for Pad User and Non-user Groups	Non-user group yielded a higher counseling rate, but not statistically significant
Filled Prescription Rate	Performance declined

VI. Deficiencies and Appeals

COMPLIANCE WITH NYS STRUCTURE AND OPERATION STANDARDS

This section of the report examines deficiencies identified by the NYSDOH in operational and focus surveys as part of the EQRO's evaluation of the MCO's compliance with State structure and operation standards.

Compliance with NYS Structure and Operation Standards

To assess the compliance of an MCO with Article 44 of the Public Health Law and Part 98 of the New York Code of Rules and Regulations (NYCRR), the NYSDOH conducts a full monitoring review of the MCO's compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories in **Table 20**. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCO is not in compliance.

The full monitoring review consists of an operational survey. The on-site component includes review of the following: policy and procedures, executed contracts and credentialing files of randomly selected providers, adverse determination utilization review files, complaints and grievances files, meeting minutes, and other documentation. Staff interviews are also conducted. These reviews are conducted using two standardized tools, the "Medicaid Managed Care Contract Surveillance Tool" and the "Review Tool and Protocol for MCO Operational Surveys." The NYSDOH retains the option to deem compliance with standards for credentialing/ recredentialing, quality assurance/improvement, and medical record review.

The Monitoring Review Report documents any data obtained and deficiencies cited in the survey tools. Any statements of deficiencies (SODs) are submitted to the MCO after the monitoring review, and the MCO is required to respond with a plan of corrective action (POC). POCs must be submitted to the NYSDOH for acceptance. In some cases, revisions may be necessary and MCOs are required to resubmit. Ultimately, all MCOs with SODs must have a POC that is accepted by the NYSDOH. During the alternate years when the full review is not conducted, the NYSDOH reviews any modified documentation and follows up with the MCO to ensure that all deficiencies or issues from the operational survey have been remedied.

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of structure and operation standards. The focused review types are summarized in **Table 19**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 20 reflects the total number of citations for the most current operational survey of the MCO, which ended in 2014, as well as from the focused reviews conducted in 2014. This table reflects the findings from reviews of the MCO as a whole and deficiencies are not differentiated by product line. It is important to note that the number of deficiencies and the number of citations may differ, since each deficiency can have multiple citations.

Hudson was in compliance with 12 of 14 categories. The categories in which Hudson was not in compliance were Organization and Management (4 citations) and Service Delivery Network (2 citations).

Table 19: Focused Review Types

Review Name	Review Description
Access and Availability	Provider telephone survey of all MMC plans performed by the NYSDOH EQRO to examine appointment availability for routine and urgent visits; re-audits are performed when results are below 75%.
Complaints	Investigations of complaints that result in an SOD being issued to the plan.
Contracts	Citations reflecting non-compliance with requirements regarding the implementation, termination, or non-renewal of MCO provider and management agreements.
Disciplined/Sanctioned Providers	Survey of HCS to ensure providers that have been identified as having their licenses revoked or surrendered, or otherwise sanctioned, are not listed as participating with the MCO.
MEDS (Medicaid Encounter Data Set)	Citations reflecting non-compliance with requirements to report MCO encounter data to the Department of Health.
Member Services Phone Calls	Telephone calls are placed to Member Services by AO staff to determine telephone accessibility and to ensure correct information is being provided to callers.
Other	Used for issues that do not correspond with the available focused review types.
Provider Directory Information	Provider directories are reviewed to ensure that they contain the required information.
Provider Information – Web	Review of MCO's web-based provider directory to assess accuracy and required content.
Provider Network	Quarterly review of HCS network submissions for adequacy, accessibility, and correct listing of primary, specialty, and ancillary providers for enrolled population.
Provider Participation – Directory	Telephone calls are made to a sample of providers included in the provider directory to determine if they are participating, if panels are open, and if they are taking new Medicaid patients. At times, this survey may be limited to one type of provider.
QARR (Quality Assurance Reporting Requirements)	Citations reflecting non-compliance with requirements to submit MCO QARR data to the Department of Health.
Ratio of PCPs to Medicaid Clients	Telephone calls are placed to PCPs with a panel size of 1,500 or more Medicaid clients. The calls are used to determine if appointment availability standards are met for routine, non-urgent "sick", and urgent appointments.

AO: Area Office
HCS: Health Commerce System
SOD: Statement of Deficiency

Table 20: Summary of Citations

Category	Operational Citations[1]	Focused Review Citations
Complaints and Grievances		
Credentialing		
Disclosure		
Family Planning		
HIV		
Management Information Systems		
Medicaid Contract		
Medical Records		
Member Services		
Organization and Management		**4**
Contracts		*3*
Provider Participation—Directory		*1*
Prenatal Care		
Quality Assurance		
Service Delivery Network		**2**
Provider Participation—Directory		*2*
Utilization Review		
Total	**-**	**6**

[1] MCO did not have an operational survey in 2014.

VII. Strengths and Opportunities for Improvement[1]

This section summarizes the accessibility, timeliness, and quality of services provided by the MCO to Medicaid and Child Health Plus recipients based on data presented in the previous sections of this report. The MCO's strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided based on the opportunities for improvement noted. An assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report is also included in this section. The MCO's response to the previous year's recommendations, wherein the MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve, is appended to this section of the report.

Strengths

- The MCO earned PQI, compliance, satisfaction, and quality points that qualified it for 75% of the available financial incentive.
- The 2015 HEDIS® Final Audit Report revealed no significant issues and the MCO was able to report all required QARR rates.
- In regard to the Primary Care Access and Availability Survey, the MCO met the 75% compliance threshold for routine appointments, non-urgent "sick", and after hours calls.
- The MCO has reported above average rates for at least three consecutive reporting years for the following HEDIS®/QARR measures: *Follow-Up After Hospitalization for Mental Illness—30 Days, Use of Appropriate Medications for People with Asthma (Ages 5-18),* and *Annual Dental Visits (Ages 2-18).* The MCO's rates were also above average for the following HEDIS®/QARR measures: *Asthma Medication Ratio (Ages 5-18), Appropriate Testing for Pharyngitis,* and *Appropriate Treatment for Upper Respiratory Infection.*
- The MCO's rates were above average for the child CAHPS® measures *Customer Service* and *Overall Rating of Health Plan.*

Opportunities for Improvement

- The MCO continues to demonstrate an opportunity for improvement in regard to its overall HEDIS®/QARR performance. The MCO has reported below average rates for at least three consecutive reporting years for the following HEDIS®/QARR measures: *Drug Therapy for Rheumatoid Arthritis, Use of Imaging Studies for Low Back Pain, Medication Management for People with Asthma 50% of Days Covered (Ages 19-64),* and *Medication Management for People with Asthma 50% of Days Covered (Ages 5-18).* The MCO also reported below average rates for the following HEDIS®/QARR measures: *Chlamydia Screening (Ages 16-24), Breast Cancer Screening, Annual Monitoring for Patients on Persistent Medications—Combined Rate, Spirometry Testing for COPD, Well-Child Visits—3 to 6 Year Olds,* and *Well-Care Visits for Adolescents.* (Note: *Drug Therapy for Rheumatoid Arthritis, Use of Imaging Studies for Low Back Pain, Medication Management for People with Asthma 50% of Days Covered,* and *Spirometry Testing for COPD* were opportunities for improvement in the previous year's report.)
- In regard to compliance with NYS structure and operation standards, the MCO received 6 focused review citations related to Organization and Management and Service Delivery Network. (Note:

[1] This section of the report emphasizes the maintenance of current good practices and the development of additional practices resulting in improved processes and outcomes, and thus refers to "Strengths" and "Opportunities for Improvement" rather than "Strengths" and "Weaknesses" as indicated in federal regulations.

compliance with NYS structure and operation standards was an opportunity for improvement in the previous year's report.)

Recommendations

- The MCO should continue to evaluate and update its HEDIS®/QARR quality improvement strategies discussed in the response to the previous year's recommendation. Additionally, as Hudson Health Plan and MVP Health Plan have integrated their quality improvement programs, the MCO should leverage that relationship to identify and implement best practices for quality improvement. [*Repeat recommendation.*]
- The MCO should continue to work to address the issues noted in the focused reviews. As the citations the MCO received relate to provider directory information, the MCO should modify its strategy to improve the accuracy of provider network data. [*Repeat recommendation.*]

Response to Previous Year's Recommendations

- **2013 Recommendation:** The plan should continue with the HEDIS®/QARR quality improvement strategies discussed in the plan's response to the previous year's recommendation. For measures that consistently perform below the average, the health plan should modify its improvement approach based on thorough root cause analysis. [*Repeat recommendation.*]

  MCO Response: For content pertaining to Hudson Health Plan and MVP integration activities as well as activities pertaining to RY 2015 and beyond, both MVP and Hudson Health Plan experience are outlined in the ***MVP RY 2013*** Form document so as to avoid repetition and underscore the consistency between the integrated plans.

  Hudson Health Plan continued to focus on key interventions and careful, organized root cause analysis processes for RY 2014. The most notable activities were inclusive of:

  - *Member Incentive Program*—Hudson members continued to receive monetary incentives for seeking relevant preventive and/or treatment-based care for specific quality measures.
  - *Provider Incentive Program*—Hudson providers continued to receive monetary incentives for delivering preventive or treatment-based care to at-risk members; Hudson also provided aggregate level provider-specific reporting for select quality measures and met with providers to assist them with understanding and responding to their specific areas of opportunity.
  - *Member Outreach*—Hudson conducted member preventive care reminder calls; calls included an offer of assistance to set up appointments with doctors in real time. Hudson also sent mailed communications to members reminding them of the importance of receiving preventive and treatment-based services as a part of the member incentive program.
  - *Data Quality Validation ("DQV") Process*—Hudson continued to utilize its DQV measure analysis process for measures that demonstrated/continued to demonstrate performance opportunities. The DQV process is ultimately intended to provide a foundation for the identification of and response to ongoing opportunities to impact measure improvement from both a clinical and data-focused perspective. The process provides a focused, documented account of key measure performance drivers and attributes inclusive of measure specification changes, historical measure performance trends, measure interventions, and intervention evaluations. The process is accomplished through cross-functional input to ensure that functional areas across the organization are able to contribute meaningfully as all areas play a key role in and may impact the performance of quality measurement.

- *QARR Steering Committee*—Hudson continued to leverage a cross-functional steering committee for oversight and direction pertaining to the performance of QARR program measures.

All of the aforementioned activities were continuous, fully implemented, and mature interventions for RY 2014 and most continued into or were enhanced for RY 2015. RY 2015 activities are outlined within the scope of the ***MVP RY 2013*** response document.

Expected outcomes for these interventions are generally to maintain or improve the performance of Hudson Quality measures and support increased member satisfaction with the plan.

Hudson Health Plan performed annual program evaluations for the incentive and gaps-in-care interventions to monitor ongoing effectiveness. Evaluations focused on statistical analysis to correlate interventions with potential changes to measure performance. Interventions may be discontinued or changed as a result of these ongoing evaluations.

With the legacy Hudson Health Plan and MVP Medicaid license consolidation effective date at 1/1/16, the Quality Programs for both Hudson Health Plan and MVP are considered as fully integrated, and operate on a consistent enterprise strategy platform. As such, activities continued or implemented throughout MY 2015 and beyond are outlined within the ***MVP RY 2013*** Form.

- **2013 Recommendation:** The plan should continue to work to address the problems noted in the focused surveys. [*Repeat recommendation.*]

  MCO Response: Hudson received no citations for the 2014 or 2013 Article 44 Site surveys. Hudson did continue to work towards correcting issues in regard to Member Services Telephone Surveys. Hudson continued to perform ongoing trainings, review Member Services Telephone Survey results, and monitor compliance. Regarding issues cited with the Provider Directory, Hudson continued to strive to provide the most up-to-date information for our members through our provider directory activities. As Hudson representatives conducted their provider maintenance visits throughout the year, they identified any demographic or provider status changes, in addition to the updates received from provider offices. Additionally, Hudson conducted an annual Access and Availability study and updated systems and records accordingly.

VIII. Appendix

REFERENCES

A. Corporate Profile

- Updated Corporate Profile information provided by the NYSDOH
- NYSDOH OMC DataLink Reports
  - Managed Care Plan Directory, Accessed August 31, 2015
- NCQA Accreditation website, http://hprc.ncqa.org, Accessed August 31, 2015

B. Enrollment/Provider Network

1. *Enrollment*
   - NYSDOH OMC Membership Data, 2012-2014
   - Enrollment by Age and Gender Report as of December 2014
   - Enrollment Status by Aid Category and County as of December 2014
   - Enrollment Status Report, December 2014
2. *Provider Network*
   - Providers Statewide by Specialty, Medicaid Managed Care in New York State Provider Network File Summary, December 2014
   - QARR Measurement Year, 2012-2014
   - NYSDOH Primary Care Access and Availability Survey, 2014

C. Utilization

1. *Encounter Data*
   - MMC Encounter Data System, 2012-2014
2. *QARR Use of Services*
   - QARR Measurement Year, 2012-2014

D. Quality Indicators

1. *Summary of HEDIS® Information Systems Audit™ Findings*
   - 2014 Final Audit Report prepared by the MCO's Certified HEDIS® Auditors
2. *QARR Data*
   - Performance Category Analysis, Quality Performance Matrix (2014 Measurement Year)
   - QARR Measurement Year, 2012-2014
3. *CAHPS® 2014 Data*
   - QARR Measurement Year, 2014
4. *Quality/Satisfaction Points and Incentive*
   - Quality/Satisfaction Points and Incentive, 2012-2014
5. *Performance Improvement Project*
   - 2013-2014 PIP Report

E. Deficiencies and Appeals

1. *Summary of Deficiencies*
   - MMC Operational Deficiencies by Plan/Category, 2014
   - Focus Deficiencies by Plan/Survey Type/Category, 2014